SENATE JUDICIARY
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BILL NO. SB220

Opposition Testimony SB-200 - 2/11/2013
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After listening to proponents of SB 220, I wonder if we really know what we are talking about when we say Montana Death with Dignity Act – where the language cloaks the reality. This is really just a nice way of framing the notion of "Physician Assisted Suicide," which itself needs clarity.

The difference between perception and reality with Physician Assisted Suicide is critical to understand before passing any Montana legislation legalizing suicide. I have looked at the bill and the language and I'm against SB-220. Helping me reach my conclusion is Marina Vamos, a School of Medicine and Public Health Psychiatrist at the University of Newcastle, Austrtalia.

I will provide the committee a copy of my testimony and Vamos' 2012 study: "Physician Assisted Suicide: Saying what we mean and meaning what we say."

First, SB-220 alludes to "qualified patients" ending life in a "humane" and "dignified" manner. One determination of "qualified" is competent, a notoriously problematic assessment.

And how do we define humane and dignified? We may think we know, but do we? Is it meeting all the conditions of the bill or is it something else that is required: Something the qualified patient or state decides? Should dignity mean honor and esteem and go beyond notions of self-control, independence and physical strength? What I think of as humane, others may not agree.

Is there such a thing as humane and dignified suicide? Shouldn't we know what these terms mean since they are used throughout the bill?

Does Physician Assisted Suicide as spelled out in SB-220 really mean a death that is free from avoidable distress and suffering for patients, families and caregivers; in general accord with patients' and families' wishes; and reasonably consistent with clinical, cultural, and ethical standards?

To imply this, leaves out the act of killing. We are not talking about care for the dying but for the killing of a consenting person 18 years old or older. To this end, Physician Assisted Suicide is often disguised by saying "Death with Dignity." This is a deceptive euphemism that cloaks a practice which one might abhor given another name.

With Physician Assisted Suicide the emphasis on "assistance" seems to imply that physicians would be, simply, "being helpful." But if we think critically, a physician has a responsibility to assist in a very specific context. Doctors have the duty to relieve suffering and promote well-being within the domain of ill health.

If a patient asks her physician to be her lover or stockbroker, the physician will quite rightly refuse, for to acquies would violate professional boundaries. Similarly, if a patient requests his doctor to treat him in a manner that will make his illness worse, the doctor cannot provide such assistance and is obligated not to.

Can we reasonably assume that the act of suicide should be included as an area where a physician should give assistance? Studies of suicides say that 90 percent of young and old at the time of their deaths have been diagnosed with high risk mental disorders. So the answer is no.

But proponents of Physician Assisted Suicide argue that this does not apply to those with terminal illnesses as they are rational human beings wanting a sensible degree of control over their death. Again, the data do not support this. Patents with terminal illness wanting to hasten their own death have higher rates of depression, lower family cohesion and a greater sense of being a burden on their families. For these, it is not pain or health status, but hopelessness. This condition doesn't meet the qualified patient criteria in SB-220.

So how should a physician assist patients who are suicidal and easily could require considerable attention to their mental state, social context, and uniquely individual psychic factors?

With Physician Assisted Suicide we are suddenly confronted with the idea that not only should physicians not attempt to treat the despair underlying

suicidal behaviors, but also they should in fact hand over a prescription of lethal drugs. Again the language assisted suicide cloaks the reality.

If I read SB-220 correctly, the definition for "attending physician" means the doc who has primary responsibility for the care of a patient and treatment of the patient's terminal illness. But under SB-220, this physician then becomes arbiter of death under Section 6. It is up to him -- or her -- to determine if the patient is a resident of Montana, has a terminal illness that will cause death in 6 months, is competent, wants the lethal drug, is making an informed decision, knows the potential risks, has been advised of alternative or additional treatments (such as comfort care and pain control), and so forth including making sure the patient doesn't take the lethal drug in a public place.

The 6-month prognosis is used despite the well-known inaccuracy trying to gage terminal time frames. Oregon Health Authority statistics give the delay between receiving a prescription for lethal drugs to death as a maximum of 1009 days, or over 2 years. This means in Oregon lethal drugs, once prescribed, are lost in the system and can sit on a shelf for extended periods of time.

These are all complicated decisions. Are doctors in a position to manage them? Add to this the physicians own proclivities and we are faced with ordinary human beings who are unable to escape their own prejudices and biases about quality of life, a good death and whether suffering has meaning.

So it seems Physician Assisted Suicide is not so much looking after patients with terminal illnesses, but a way of handing over enormous power to physicians, asking them to act as gatekeepers of death in an atmosphere full of complexity, ambiguity and uncertainty.

If you can accommodate this in Montana law now, it will only be a short time before the floodgates of legal killing expand, finding their way into hospitals, extended care facilities and nursing homes with or without a patient's request or permission. It's already being discussed in Washington just two years after Physician Assisted Suicide became legal there.